

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
BESSIE		S		jnj		DAWSON		Oct. 4 1968		6:45 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		JAN. 1886		82 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
WEST VIRGINIA		U.S.A.				ST. MARY'S					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
LEONARDTOWN		ST. MARY'S HOSPITAL									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ST. MARY'S		ABELL							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Daniel Meryman		THOMAS		SWISHER		Emma Elmira		EDNA		KENNEDY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
						S SYLVIA D. MATTINGLEY		ABELL, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cerebral Hemorrhage										1 hour	
DUE TO, OR AS A CONSEQUENCE OF											
(b) Generalized Anterograde											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
331X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 10-4-68, 1968 that (I) (we) last saw the deceased alive on 10-4-68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
W. H. Patrick		10-4-68		WILLIAM H. PATRICK M. D.		LEXINGTON PARK, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		Oct. 8, 1968		ARLINGTON NATIONAL		ARLINGTON, VIRGINIA					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W. CLARKE MATTINGLEY		LEONARDTOWN, MARYLAND		DATE OCT 9 1968		J. Charles Judge					

14583

DATE OF BIRTH

SEX

AGE

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EYES

TEETH

SCARS

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VR A1547  
30M REV. 1-68

<div style="display: flex; justify-content: space-between;"> <span>14985</span> <span> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</b>  <b>CERTIFICATE OF DEATH</b> </span> <span>14994</span> </div>									
1. DECEASED-NAME (Type or print) <b>Benjamin Enoch Dent</b>						2a. DATE OF DEATH Month <b>Sept.</b> Day <b>9</b> Year <b>1968</b>		2b. HOUR <b>8:45</b> P	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 9, 1897</b>		6. AGE (In years lost birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS <b>71</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>St. Mary's Co.</b> Md.			
10. CITY OR TOWN OF DEATH <b>Drayden</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Mary's</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Merchant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Drayden, Maryland</b>		13b. COUNTY <b>St. Mary's</b>		13c. CITY OR TOWN <b>Drayden</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME <b>James Wilson Dent</b> First Middle Last				15. MOTHER'S MAIDEN NAME <b>Mary Queenie Combs</b> First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>Mary Dent Berryman, Drayden, Md.</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>011.9</b> IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Lobar Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Pulmonary Tuberculosis</b> Approximate interval between onset and death: <b>2 weeks</b> <b>1 month</b> <b>10 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>002.1</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b>323 Midway Drive</b>		City or Town <b>Lexington Park</b>		County <b>Bladensburg</b> State <b>MD.</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1968</b> to <b>Oct. 1, 1968</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Oct. 1, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.									
22b. SIGNATURE <b>W.H. Patrick M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-1-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>William H. Patrick, M.D.</b>				22e. ADDRESS <b>323 Midway Drive, Lexington Park, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>OCT. 5, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEM.</b>		23d. LOCATION (City or Town) <b>BLADENSBURG, MD.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO, INC.</b>				ADDRESS <b>3072 "M" ST. N.W. WASHINGTON, DC</b>		25a. REC'D BY REGISTRAR <b>OCT 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

100-100000

STATE OF TEXAS

100-100000

Benjamin Enoch Gent 100-100000

White Sept. 1, 1897 71

Married U.S. 100-100000

Raydon Merchants Retail

Raydon, Mary Ann, Raydon

James Wilson Gent Mary Queenie Jones

Raydon, Mary Ann, Raydon, E.

Heart Failure 2 weeks

Liver trouble 1 month

Chronic Pulmonary Tuberculosis 10 years

William, E. T. 100-100000  
Married, living, Texas

100-100000

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VR A15  
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14986

Item 11 Film 61 1967-68

CERTIFICATE OF DEATH

14995

1. DECEASED-NAME (Type or print) <b>MARTHA DAVIS FARR</b>			2a. DATE OF DEATH Month <b>October</b> , Day <b>8</b> , Year <b>1968</b>			2b. HOUR <b>M</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>NOVEMBER 16, 1898</b>		6. AGE (In years lost birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARY'S</b> Md.				
10. CITY OR TOWN OF DEATH <b>VALLEY LEE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rural Area</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ST. MARY'S</b>		13c. CITY OR TOWN <b>LEONARDTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <b>LOUIS H. DAVIS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MOLLY LOVE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MRS EMILY F. LATHAM LEONARDTOWN, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Suit ASCVD</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>10 yr</b> <b>year</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1967</b> to <b>Oct 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>J. Mossman</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-9-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>DAVID MOSSMAN M. D.</b>						22e. ADDRESS <b>MECHANICSVILLE, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>OCT. 10, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BUSHWOOD, ST. MARY'S, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

MEDICAL CERTIFICATION

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

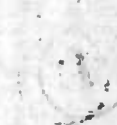
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 407 Maryland State Department of Health  
12-9-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**14987** MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14996

1. DECEASED-NAME (Type or Print) First Middle Last <b>ROSE MARIE GUY</b>			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10-9 1968 2b. HOUR 2:45 PM		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Nov. 27, 1953</b>	6. AGE (In years last birthday) <b>15</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Mary's Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>St. Mary's</b>		13c. CITY OR TOWN <b>Colton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last <b>MATTINGLEY GUY</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>ALICE CULLINS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>ALICE C. GUY COLTON P. INT. MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>5400</b> IMMEDIATE CAUSE (a) <b>Gangrenous appendicitis with perforation and peritonitis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>5501</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED <b>October 10, 1968</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>OCT. 12, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEMETERY</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>OCT 15 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

FOR STATE  
HEALTH DEPT



W. CLARK ATTORNEY, EDWARDSVILLE, ILLINOIS

OCT 15 1908

BURIAL OCT. 15, 1908 GARDEN MEARY CEMETERY BURNING, ST. LOUIS, ILLINOIS

EDWARDSVILLE, ILLINOIS

OCTOBER 15, 1908

EDWARDSVILLE, ILLINOIS

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VR A15  
30M REV.

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH			2b. HOUR			
				Month	Day	Year			M				
ROBINSON				HAROLD		HARSH		OCTOBER 9		1968			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE		WHITE		OCT. 9, 1894			74 YRS.		MONTHS		HOURS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
TEXAS		U.S.A.				ST. MARY'S Md.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
LEONARDTOWN				ST. MARY'S HOSPITAL			RETIRES CIVIL SERVICE						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND				ST. MARY'S		HOLLYWOOD		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RTE 2 Box			
14. FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME				First	Middle	Last
HENRY				R		HARSH	EMMA						TAYLOR
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
						MRS LESLIE M. HARSH CALIFORNIA, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 CONGENITAL HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CONGENITAL DILATATION OF THE HEART DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
											4 yr		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201											year		
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1964 to 1968, that (I) (we) last saw the deceased alive on Oct 19 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE							DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)							22e. ADDRESS						
DAVID MOSSMAN M. D.							MECHANICSVILLE, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
BURIAL				OCT. 11, 1968		JOY CHAPEL CEMETERY			HOLLYWOOD, ST. MARY'S, MARYLAND				
24. FUNERAL DIRECTOR ADDRESS							25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND							DATE OCT 15 1968		Charles Judge				

14088

WILLIAM C. COVIL

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14989

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14997

1. DECEASED-NAME (Type or Print) <b>EDWARD LEE HAMMETT</b>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>Oct. 13, 1968</b>			2b. HOUR <b>M</b>		
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>SEPT. 15, 1954</b>	6. AGE (In years last birthday) <b>14</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <b>Oct.</b> Day <b>14,</b> Year <b>19 68</b>		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARY'S</b> Md.		
10. CITY OR TOWN OF DEATH <b>COMPTON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ST. MARY'S</b>		13c. CITY OR TOWN <b>COMPTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
14. FATHER'S NAME First <b>DANIEL</b> Middle <b>F.</b> Last <b>HAMMETT</b>			15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>T.</b> Last <b>HAYDEN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS <b>MARY H. HAMMETT Rt. 2 Box 31 LEONARDTOWN, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>9220</b> IMMEDIATE CAUSE (a) <b>gun shot</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immed</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>9191</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>11:00 PM 10-13 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Shot self while hunting in woods</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>BEECH CLARK FARM</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>Compton St Marys Md</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>William D. Boyd</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>10-17-68</b>		
EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M. D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>OCT. 17, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. FRANCIS XAVIER</b>		23d. LOCATION (City or Town) (County) (State) <b>COMPTON, ST. MARY'S, Md.</b>		
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1958

14990										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14999																																							
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR M																																							
3. SEX MALE										4. RACE CAU.										5. DATE OF BIRTH April 21, 1882										6. AGE (In years lost birthday) 86 YRS.										7. UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ST MARYS Md.																													
10. CITY OR TOWN OF DEATH LEONARDTOWN										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NURSING HOME										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER										12b. KIND OF BUSINESS OR INDUSTRY TOBACCO																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.										13b. COUNTY CHARLES										13c. CITY OR TOWN HUGHESVILLE										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
14. FATHER'S NAME First Middle Last RICHARD JAMESON										15. MOTHER'S MAIDEN NAME First Middle Last CECELIA WHEATLEY																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO										16b. SOCIAL SECURITY NO. 220-348-2294										17. INFORMANT Address WALTER A. JAMESON JR, HUGHESVILLE, MD.																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Corneal Artery Infection APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE [Signature]										22c. DATE SIGNED 10/24/68																																							
22d. PHYSICIAN'S NAME (Type) E. J. GUAZZO M.D.										22e. ADDRESS MECHANICSVILLE, MD.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 10-28-68										23c. NAME OF CEMETERY OR CREMATORY ST MARYS CEM.										23d. LOCATION (City or Town) (County) (State) BRYANTOWN, CHARLES, MD.																													
24. FUNERAL DIRECTOR HUNTT FUNERAL HOME, WALDORF, MD.										25a. REC'D BY REGISTRAR DATE OCT 29 1968										25b. REGISTRAR'S SIGNATURE [Signature]																																							

1999

CERTIFICATE OF DEATH

1999

Corporation West Virginia  
Corporation West Virginia

A large, stylized handwritten signature in dark ink, possibly reading "J. J. Jones" or similar, with a horizontal line underneath.

1999



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13 Film 406 11/6/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14991

CERTIFICATE OF DEATH

15000

1. DECEASED-NAME (Type or print) First Middle Last <b>BEULAH</b> <b>NEA.</b> <b>KINCAID</b>			2a. DATE OF DEATH Month Day Year <b>OCTOBER 25 1968</b>			2b. HOUR M <b>15000</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JULY 31, 1904</b>		6. AGE (In years lost birthday) <b>64</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARY'S</b> Md.	
10. CITY OR TOWN OF DEATH <b>LEONARDTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARY'S HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ST. MARY'S</b>		13c. CITY OR TOWN <b>Hollywood</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First Middle Last <b>EDWARD</b> <b>O'CONNOR</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MAGGIE</b> <b>FORD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>GEORGE L. KINCAID</b>		Address <b>HOLLYWOOD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Germany Occlusion</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Germany Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>2404</b> , 19 <b>68</b> , to <b>2504</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2504</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Ernest D. Rehm</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>17 OCT 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>ERNEST REHM, M.D.</b>				22e. ADDRESS <b>LEXINGTON PARK, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>OCT. 28, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY MEMORIAL GARDENS</b>		23d. LOCATION (City or Town) (County) (State) <b>WALDORF CHARLES MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>				25a. REC'D BY REGISTRAR <b>LEONARDTOWN, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



100

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14892

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15001

1. DECEASED-NAME (Type or Print) <b>DENNIS WILLIAM LAWRENCE</b>			2a. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> <b>OCT. 9, 1968</b>			2b. HOUR <b>M</b>				
3. SEX <b>MALE</b>	4. RACE <b>NEGRO</b>	5. DATE OF BIRTH <b>OCT. 17, 1898</b>	6. AGE (In years last birthday) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <b>OCTOBER</b> Day <b>9</b> Year <b>1968</b>			2d. HOUR <b>M</b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARY'S</b> Md.				
10. CITY OR TOWN OF DEATH <b>CALLAWAY</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ST. MARY'S</b>			13c. CITY OR TOWN <b>CALLAWAY</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER			14. FATHER'S NAME First <b>JOHN</b> Middle <b>FRANCIS</b> Last <b>LAWRENCE</b>			15. MOTHER'S MAIDEN NAME First <b>MAGGIE</b> Middle <b>WHALEN</b> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. <b>215-14-7272A</b>			17. INFORMANT <b>EVELYN SAXON</b>			ADDRESS <b>CALLAWAY, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>890X</b> IMMEDIATE CAUSE (a) <b>ASPHYXIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HOMICIDE</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>9160</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>10:30 PM 10-9 1968</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>House Fire</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>at Home</b>			21f. LOCATION Street or R.F.D. No. <b>CALLAWAY, ST. MARY'S, MARYLAND</b> City or Town <b>ST. MARY'S, MARYLAND</b> County <b>ST. MARY'S, MARYLAND</b> State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>W.D. Boyd</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>OCTOBER 9, 1968</b>				
EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M. D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
ADDRESS (Street, city, town, or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>OCT. 12, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARKS CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>VALLEY LEE, ST. MARY'S, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b> ADDRESS <b>LEONARDTOWN, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>OCT 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

12001

AND CALIFORNIA COUNTY OF DEATH

1000

FOR SALE



DEATH CERTIFICATE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

ST. LAWRENCE, CALIFORNIA

FRANCIS LAWRENCE

VALLEY VIEW, CALIFORNIA

DEATH OF

DEATH OF

DEATH OF

DEATH OF

DEATH OF

DEATH OF

DEATH OF

DEATH OF

DEATH OF

DEATH OF

DEATH OF

FOR STATE  
HEALTH DEPT.


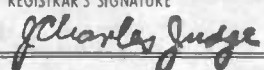
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14993

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15002

1. DECEASED-NAME (Type or Print)			First <b>JAMES</b>			Middle <b>ARTHUR</b>			Last <b>LAWRENCE</b>			2a. DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <b>OCT. 9,</b> 19 <b>68</b>			2b. HOUR <b>M</b>		
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>MAY 16, 1964</b>		6. AGE (In years last birthday) <b>4</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <b>OCTOBER 9,</b> 19 <b>68</b>			2d. HOUR <b>M</b>		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ST. MARY'S</b> Md.								
10. CITY OR TOWN OF DEATH <b>CALLAWAY</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY <b>ST. MARY'S</b>		13c. CITY OR TOWN <b>CALLAWAY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER							
14. FATHER'S NAME First Middle Last <b>JAMES A. LAWRENCE</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>AGNES ELIZABETH GREENE</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)									
16b. SOCIAL SECURITY NO.				17. INFORMANT <b>MOTHER</b>				ADDRESS <b>CALLAWAY, MARYLAND</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPHYXIA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>890X</b> (b) <b>HOUSE FIRE</b> DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN.</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>9160</b>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>10 30 PM 10-9 1968</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>House Fire</b>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>at Home</b>				21f. LOCATION Street or R.F.D. No. City or Town County State <b>CALLAWAY, ST. MARY'S, MARYLAND</b>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE 				M.D. EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M. D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED <b>OCTOBER 9, 1968</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>OCT. 12, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARK'S CEMETERY</b>				23d. LOCATION (City or Town) (County) (State) <b>VALLEY LEE, ST. MARY'S, MARYLAND</b>							
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>						ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 15 1968</b>				25b. REGISTRAR'S SIGNATURE 					

15003

15003

15003

JAMES A. LARSON  
BORN MAY 10, 1904  
U.S.A.  
CALIFORNIA

JAMES A. LARSON  
BORN MAY 10, 1904  
U.S.A.  
CALIFORNIA

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BORN MAY 10, 1904  
U.S.A.  
CALIFORNIA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MIDDLE										15003						
1. DECEASED-NAME (Type or print)			First OCEY			Middle MAE			Last PATTY			2a. DATE OF DEATH Month 5, Day 1968			2b. HOUR M	
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH FEB. 2, 1927			6. AGE (In years last birthday) 41 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ST. MARY'S Md.							
10. CITY OR TOWN OF DEATH LEONARDTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ST. MARY'S			13c. CITY OR TOWN LEXINGTON PK.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 1 LEVIN DRIVE				
14. FATHER'S NAME First Middle Last JAMES LEE McCLENNEY			15. MOTHER'S MAIDEN NAME First Middle Last MARTHA L. ROUNDTREE													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Address WILL T. PATTY 1 LEVIN DRIVE LEXINGTON PK., MD.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 486X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure (c) Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours 24 hrs																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 493X																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 15 Sep 1968 to 5 Oct 1968, that (I) (we) lost saw the deceased alive on 5 Oct 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Ernest M. Rehm			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 6 Oct 68	
22d. PHYSICIAN'S NAME (Type) ERNEST REHM M. D.			22e. ADDRESS LEXINGTON PARK, MARYLAND													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE Oct. 9, 1968			23c. NAME OF CEMETERY OR CREMATORY WOODLAND			23d. LOCATION (City or Town) (County) (State) SUFFOLK, NANSEMOND, VIRGINIA							
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND			25a. REC'D BY REGISTRAR DATE OCT 9 1968			25b. REGISTRAR'S SIGNATURE Charles Judge										

12003

12003

DATE: 10/10/1964

TO: JAMES E. HODGINS

FROM: ST. JAMES' HOSPITAL

SUBJECT: ST. JAMES' HOSPITAL

RE: ST. JAMES' HOSPITAL

DATE: 10/10/1964

TO: JAMES E. HODGINS

FROM: ST. JAMES' HOSPITAL

SUBJECT: ST. JAMES' HOSPITAL

RE: ST. JAMES' HOSPITAL

DATE: 10/10/1964

TO: JAMES E. HODGINS

FROM: ST. JAMES' HOSPITAL

SUBJECT: ST. JAMES' HOSPITAL

RE: ST. JAMES' HOSPITAL

DATE: 10/10/1964

TO: JAMES E. HODGINS

FROM: ST. JAMES' HOSPITAL

12003

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14995

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15004

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
CHARLES VERNON RUSSELL						OCT. 15, 1968						M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
MALE		WHITE		MAY 26, 1939		29 YRS.		MONTHS DAYS		HOURS MIN.		Month Day Year		
												OCT. 15, 1968		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
MARYLAND			U.S.A.						ST. MARY'S			LANGFELLOW		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
LEONARDTOWN			ST. MARY'S HOSPITAL			HEAVY EQU. OPERATOR								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
MARYLAND			ST. MARY'S			HOLLYWOOD			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
JOHN			CATHERINE						220-34-3771			CATHERINE D. RUSSELL HOLLYWOOD, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		
PART I. DEATH WAS CAUSED BY:			PART I. DEATH WAS CAUSED BY:			PART I. DEATH WAS CAUSED BY:			PART I. DEATH WAS CAUSED BY:			PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a)			IMMEDIATE CAUSE (a)			IMMEDIATE CAUSE (a)			IMMEDIATE CAUSE (a)			IMMEDIATE CAUSE (a)		
819.9			819.9			819.9			819.9			819.9		
Laceration of Brain			Laceration of Brain			Laceration of Brain			Laceration of Brain			Laceration of Brain		
DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF		
Fractured Skull			Fractured Skull			Fractured Skull			Fractured Skull			Fractured Skull		
DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		
8254			8254			8254			8254			8254		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			19c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
						Auto accident								
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			21d. LOCATION Street or R.F.D. No.			21e. CITY OR TOWN		
CAUSE OF DEATH			6:00 PM 10-15 1968			Auto accident			Laurel Grove			St Marys Md		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			21g. CITY OR TOWN			21h. COUNTY		
ROUTE 235														
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:			22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:			22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:			22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:			22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE			ACTUAL SIGNATURE			ACTUAL SIGNATURE			ACTUAL SIGNATURE			ACTUAL SIGNATURE		
WILLIAM D. BOYD M.D.			WILLIAM D. BOYD M.D.			WILLIAM D. BOYD M.D.			WILLIAM D. BOYD M.D.			WILLIAM D. BOYD M.D.		
EXAMINER'S NAME (Type)			EXAMINER'S NAME (Type)			EXAMINER'S NAME (Type)			EXAMINER'S NAME (Type)			EXAMINER'S NAME (Type)		
WILLIAM D. BOYD M.D.			WILLIAM D. BOYD M.D.			WILLIAM D. BOYD M.D.			WILLIAM D. BOYD M.D.			WILLIAM D. BOYD M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			23e. REC'D BY REGISTRAR		
BURIAL			OCT. 18, 1968			ST. JOHNS CEMETERY			HOLLYWOOD, ST. MARY'S, MARYLAND			OCT 21 1968		
24. FUNERAL DIRECTOR			24. FUNERAL DIRECTOR			24. FUNERAL DIRECTOR			24. FUNERAL DIRECTOR			24. FUNERAL DIRECTOR		
W. CLARKE MATTINGLEY			W. CLARKE MATTINGLEY			W. CLARKE MATTINGLEY			W. CLARKE MATTINGLEY			W. CLARKE MATTINGLEY		
LEONARDTOWN, MARYLAND			LEONARDTOWN, MARYLAND			LEONARDTOWN, MARYLAND			LEONARDTOWN, MARYLAND			LEONARDTOWN, MARYLAND		
25a. REC'D BY REGISTRAR			25a. REC'D BY REGISTRAR			25a. REC'D BY REGISTRAR			25a. REC'D BY REGISTRAR			25a. REC'D BY REGISTRAR		
OCT 21 1968			OCT 21 1968			OCT 21 1968			OCT 21 1968			OCT 21 1968		
25b. REGISTRAR'S SIGNATURE			25b. REGISTRAR'S SIGNATURE			25b. REGISTRAR'S SIGNATURE			25b. REGISTRAR'S SIGNATURE			25b. REGISTRAR'S SIGNATURE		
J. Charles Judge			J. Charles Judge			J. Charles Judge			J. Charles Judge			J. Charles Judge		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14996

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15005

1. DECEASED-NAME (Type or Print) <b>GRACE DYSON SWANN</b>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>OCT. 26, 1968</b>			2b. HOUR <b>M</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>DECEMBER 11, 1885</b>		6. AGE (In years last birthday) <b>82</b>		7. IF UNDER 1 YEAR <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.			
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ST. MARY'S</b>		
10. CITY OR TOWN OF DEATH <b>LEONARDTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARY'S HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ST. MARY'S</b>			13c. CITY OR TOWN <b>COLTON POINT</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First <b>WILLIAM</b> Middle <b>O.</b> Last <b>DYSON</b>			15. MOTHER'S MAIDEN NAME First <b>COLUMBIA</b> Middle <b>JOSEPHINE</b> Last <b>LUCKETT</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		
17. INFORMANT <b>MRS OLGA S. HAMER</b>			ADDRESS <b>HUGHESVILLE, MARYLAND</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Cardiac arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio Sclerosis H D</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 years</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4200</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>William D. Boyd M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M. D.</b>			ADDRESS (Street, city, town, or county)			22b. DATE SIGNED <b>OCTOBER 27, 1968</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>OCT. 29, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>CEBAR HILL</b>			23d. LOCATION (City or Town) (County) (State) <b>PRINCE GEORGE SUTLAND, ST. MARY'S, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>						25a. REC'D BY REGISTRAR <b>OCT 30 1968</b>					
ADDRESS <b>LEONARDTOWN, MARYLAND</b>						25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

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ANALYSIS

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**THEORY**

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ALYON, K. O. S. J. Y. L. T. H. J.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14997

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

15006

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
ANNIE		CECELIA	SWEENEY	OCTOBER 2, 1968				
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE	WHITE		JAN. 7, 1884		84 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		U.S.A.				ST. MARY'S Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
HOLLYWOOD,								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		ST. MARY'S		HOLLYWOOD				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
First Middle Last			First Middle Last					
JOHN WILLIAM DAVIS			ELIZABETH HOWARD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
					WILMER F. SWEENEY BRYANS ROAD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vess. Accident</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>7221</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1967</u> , to <u>Oct 2, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 1967</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Leon Berube</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10/6/68</u>		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
LEON BERUBE M. D.				MECHANICSVILLE, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		OCT. 5, 1968		ST. JOHNS CEMETERY		HOLLYWOOD, ST. MARY'S, MARYLAND		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				DATE OCT 9 1968		<u>Charles Judge</u>		

*[Faint handwritten notes]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV 1/68

MIDDLE										LAST		2a. DATE OF DEATH		2b. HOUR			
1. DECEASED-NAME (Type or print) <b>ROBERT</b>										<b>IGNATIUS</b>		<b>TONEY</b>		Month <b>OCTOBER</b> Day <b>7</b> Year <b>1968</b>		M <b>M</b>	
3. SEX <b>MALE</b>			4. RACE <b>NEGRO</b>			5. DATE OF BIRTH <b>AUGUST 31, 1885</b>			6. AGE (In years last birthday) <b>73</b> YRS.			IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>			
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ST. MARY'S</b> Md.								
10. CITY OR TOWN OF DEATH <b>PARK HALL</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>PARK HALL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ST. MARY'S</b>			13c. CITY OR TOWN <b>PARK HALL</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER					
14. FATHER'S NAME First <b>JAMES</b> Middle <b>TONEY</b> Last <b>TONEY</b>			15. MOTHER'S MAIDEN NAME First <b>J</b> Middle <b>J</b> Last <b>J</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>ROBERT M. TONEY</b> Address <b>RTE 1 Box 342 LEXINGTON</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b>															<b>hrs</b>		
4129 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Heart Failure</b>															<b>hrs</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Coronary Artery Disease</b>															<b>hrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>10/7/68</b> to <b>10/7/68</b> , that (I) (we) last saw the deceased alive on <b>10/7/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>J. PATRICK JARBOE, M.D.</b>			22c. DATE SIGNED <b>10/10/68</b>			22d. PHYSICIAN'S NAME (Type) <b>J. PATRICK JARBOE, M.D.</b>											
22e. ADDRESS <b>GREAT MILLS, MARYLAND.</b>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>OCT. 11, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>ST. PETER CLAVER</b>			23d. LOCATION (City or Town) (County) (State) <b>RIDGE, ST. MARY'S, Md.</b>								
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>			24b. ADDRESS <b>LEONARDTOWN, Md.</b>			25a. REC'D BY REGISTRAR <b>OCT 15 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

<div>4</div> <div>1</div> <div>14999</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>15008</div>											
1. DECEASED-NAME (Type or print) <b>DOROTHY ELIZABETH WILLIAMS</b>						2a. DATE OF DEATH Month <b>OCTOBER</b> Day <b>29</b> Year <b>1968</b>			2b. HOUR M		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 11, 1900</b>			6. AGE (In years lost birthday) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>WASHINGTON D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARY'S</b> Md.					
10. CITY OR TOWN OF DEATH <b>LEONARDTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARY'S HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ST. MARY'S</b>		13c. CITY OR TOWN <b>COMPTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last <b>CHARLES BOYDEN WILLIAMS</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>EMMA H. WILTBERGER</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16b. SOCIAL SECURITY NO.				17. INFORMANT <b>MATTIE W. SWITZER 8019 EASTERN AV. MD.</b>				Address <b>SILVER SPRING</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio-Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>443X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 1, 1968</b> , to <b>OCT 29, 1968</b> , that (I) (we) last saw the deceased alive on <b>OCT 29, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Charles Greenwell M.D.</b>										22c. DATE SIGNED <b>OCT 30 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>CHARLES GREENWELL, M.D.</b>					22e. ADDRESS <b>LEONARDTOWN, MARYLAND.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10.31. '68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. ANDREWS</b>			23d. LOCATION (City or Town) (County) (State) <b>LEONARDTOWN ST. MARY'S MD.</b>				
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>					ADDRESS <b>LEONARDTOWN, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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